Required Medicaid Therapy Services Supporting Documentation

The following supporting documentation is essential and required for claim submission and medical necessity determination review. The Medical Care Unit (MCU) must receive supporting documentation prior to the participant reaching the OT or PT/SLP limitation to ensure that therapy services are not denied solely for lack of documentation. Furthermore, in submitting all of the supporting documentation listed below, MCU staff will have information to complete medical necessity determinations. Supporting documentation must be submitted **yearly** prior to the participant reaching the therapy limitation cap.

Please fax or mail the following supporting documentation to the MCU prior to appending a KX modifier to claim submissions. Please include a completed Therapy Services Documentation Coversheet with the supporting documentation.
Current Plan of Care (POC) to include measurable short and long term goals, frequency and duration of the recommended therapy, and dated signature of both therapist and Primary Care Physician. The POC must also include a Home Exercise Program (HEP) and a discharge plan. The plan must have reasonable and reachable goals within an appropriate time frame. For example, if an individual has a diagnosis that precludes them from reaching any further functional progress and the POC goals are to reach functional levels within normal limits for his/her age and medical necessity criteria is not met. This would be considered a maintenance program.
Physician Orders: All therapy must be ordered by a physician, nurse practitioner, or physician assistant. Orders must include the service to be provided, frequency and where applicable the duration of each therapy session. (A Healthy Connections Referral usually does not meet requirements).
Current Annual Evaluation/Assessment: The Evaluation should include general health status and diagnosis, medical/surgical history and current conditions. The Evaluation should include a standardized, norm referencing assessment. If a standardized evaluation is not appropriate for the participant, the evaluation should include therapist's observations, parental/caregiver's observations, description of the participant's deficiencies and strengths and the medical necessity for skilled therapy services. The Evaluation must be completed annually and must be signed and dated by the therapist administering the assessment.
Current Progress Report: The Progress Report may be included in the current POC. This piece of documentation is an essential component in determining if continued skilled therapy services are medically necessary. The Progress Report must clearly show measurable and substantial gains which have been achieved since the previous evaluation.
Daily Therapy Treatment Notes: Treatment notes are not required to be submitted to Medicaid, but the MCU staff may request treatment notes to assist with determination of medical necessity and/or skilled therapy services. Treatment notes from the last 30 days which include the specific drills, techniques, exercises, treatments, or activities that were completed during that session and the participant's response to those treatments.

Common reasons for denial of additional skilled therapy are due to the following:

- The participant has reached a functional level that shows very minimal or no progress.
- The participant can be discharged to HEP where the parent(s) and/or caregiver(s), having been educated by the therapist, can follow through with the treatments or exercises in the home environment.
- Group therapy is being provided.
- The therapy being provided is not medically necessary. Medical necessity is defined in IDAPA rule 16.03.09.011.14.a-c. as:
 - The service must be reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction.
 - There is no other equally effective course of treatment, which is more conservative or costs substantially less, that is available or suitable for the participant. Medical services must be of a quality that meets professionally recognized standards of health care.

Revised 2-8-13 Page 1